age was 67 ± 7 years. Mean ABI was 0.85 ± 0.23. The omega-3 index decreased across AHA hsCRP categories (Fig; $P = .04$). One percentage point decrease in the omega-3 index was associated with increases in CRP (14%, 95% CI 0; 25; $P = .04$), IL6 (8%; 95% CI, 1-15; $P = .02$) and possibly ICAM-1 (4%; 95% CI, 1-12; $P = .13$), but not TNF-α. After adjusting for age, race, HDL, smoking status, ABI and the body-mass index, the omega-3 index remained significantly (negatively) associated with systemic inflammation as measured by hsCRP in a male population at risk or suffering from PAD ($P = .05$).

Conclusions: In a contemporary cohort of patients with PAD, the omega-3 index was negatively associated with biomarkers of inflammation. Our findings suggest a rationale for future studies of dietary manipulation of omega-3 index to reduce inflammation in patients with PAD.

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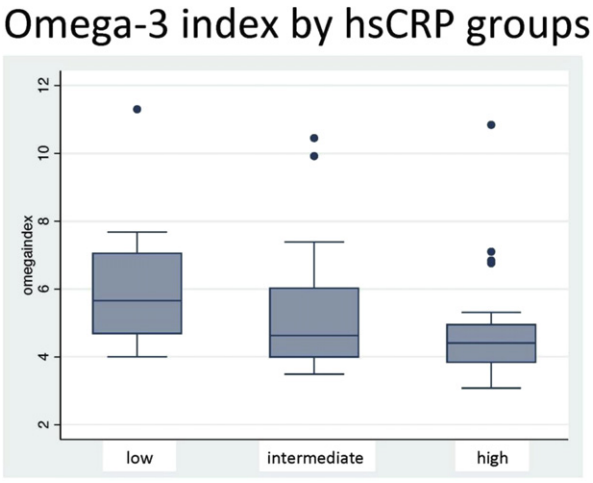

Fig.

PVSS16.

Expanded Polytetrafluoroethylene (ePTFE) Versus Autologous Vein as a Conduit for Vascular Reconstruction in Modern Combat Casualty Care

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Objectives: Reconstruction of vascular injury often requires autologous vein (AV) or expanded polytetrafluoroethylene (ePTFE) conduit. To date the durability of ePTFE as an adjunct to vascular repair in the combat setting is unknown. The objective of this study is to compare the long-term effectiveness of ePTFE to AV in repair of wartime vascular injury.

Methods: US service personnel undergoing vascular repair (2002-2012) were identified. Patients in whom ePTFE was used as an interposition conduit (n = 25) were matched to those who received AV (n = 24). Injury and operative factors were assessed and freedom from graft-related complication quantified using Kaplan-Meier log-rank test.

Results: Follow up for the ePTFE and AV groups was 71 and 62 months respectively. There was no difference between ePTFE and AV groups in age, injury severity or, mangled extremity severity scores. In the overall cohort there was an apparent but not significantly greater freedom from graft related complication for AV compared to ePTFE (65.4% vs 17.1%; $P = .13$). In the extremity position AV demonstrated greater freedom from graft related complication than ePTFE (Fig). In the carotid/subclavian/axillary positions ePTFE performed equally well as AV ($P = .9$).

Conclusions: Autologous vein is a more durable conduit than ePTFE in repair of wartime extremity vascular injury while ePTFE is effective and durable in the carotid, subclavian, and axillary locations.

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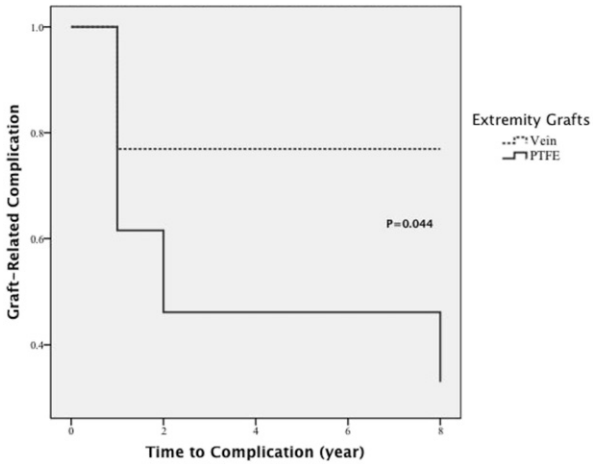

Fig. This figure displays FGRC in extremity PTFE grafts was 15.4%/8.05 yr and 76.9%/8.05 yr for extremity autologous vein grafts ($P = .044$).

PVSS17.

Surgical Revision for Non-Maturing Arteriovenous Fistulas

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